Health Equity Impact Assessment (HEIA) Workbook: How to conduct HEIA

Ontario

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Acknowledgements

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Getting Started

Using This Workbook

Health Equity Impact Assessment (HEIA) has broad application and is intended for use within the Ministry of Health and Long-Term Care (MOHLTC), within Local Health Integration Networks (LHINs) and at the health service provider level. This Workbook provides general information on how to conduct a Health Equity Impact Assessment and how to use the HEIA Tool.

This workbook:

- Leads assessors through conducting HEIA step-by-step;
- Provides examples and prompts to illustrate how each section of the tool can be filled out;
- Provides space to fill out the answers to each question.

Working through the stages within the workbook will assist in completing the HEIA Tool.

Definitions

Health Equity

Within the health system, equity means reducing systemic barriers to equitable access to high quality health care for all; addressing the specific health needs of people all along the social gradient, including the most health disadvantaged populations; and ensuring that the ways in which health services are provided and organized contributes to reducing overall health disparities.

Simply put, health inequities or disparities are differences in health outcomes that are avoidable, unfair and systematically related to social inequality and marginalization. Research shows that the roots of health disparities lie in broader social and economic inequality and exclusion, and that there are clear social gradients in which people's health tends to be worse the lower down the hierarchies of income, education and overall privilege. Health equity, then, works to reduce or eliminate socially structured health inequalities and differential health outcomes. It is linked with broader ideas about fairness, social justice, and civil society.

HEIA: Health Equity Impact Assessment

Health Equity Impact Assessment (HEIA)[1] is a flexible and practical assessment tool that can be used to identify *unintended* potential health impacts (positive or negative) of a plan, policy or program on vulnerable or marginalized groups within the general population. In identifying those impacts, the assessor can then make recommendations to decision makers as to what adjustments to the initiative might mitigate negative impacts and maximize positive impacts on the impacted groups identified. *It is important to emphasize that HEIA is focused on the identification of unintended positive and negative impacts only—not the intended benefits of the planned initiative.*

The primary focus of this tool is to reduce inequities that result from barriers to access and quality of health services and increase positive health outcomes by identifying and mitigating *unintended* impacts of an initiative prior to implementation. Broader corporate initiatives such as strategic and business planning, budget/resource allocation, accreditation, governance, accountability, regulatory, and community engagement processes can also benefit from HEIA, as it supports the integration of health equity throughout an organization. While primarily applied during the design phase of an initiative, it can also be applied retrospectively to review processes, evaluations and decisions regarding the expansion, realignment, or closure of existing programs or services.

On a macro level, the tool can be used on policies, strategies or to assess the "mix" of programs/initiatives to determine whether that mix will result in equal benefit across the population or whether it will exacerbate existing health inequities. It may also be useful in identifying equity-based indicators of success.

Social Determinants of Health

The most effective way to address health disparities is grounded in a framework that includes consideration of the social determinants of health (SDoH)—looking beyond the traditional confines of the health care system, focusing "upstream" on a broad range of socio-economic influences and outcomes that affect individual, community and population health.

The Commission on Social Determinants of Health established by the World Health Organization (WHO) states that "health care is an important determinant of health. Lifestyles are important determinants of health, but it is factors in the social environment that determine access to health services and influence lifestyle choices in the first

[1]Health Equity Impact Assessment arose out of Health Impact Assessment (HIA) methodology which has gathered considerable momentum internationally over the past decade as a decision support tool to enable "healthy public policy". While HIA often addresses health inequities, its structure did not lend itself to a more targeted and systematic focus on health inequities. As a result, a model of equity-focused Health Impact Assessment evolved and is currently in use in the U.K. (Wales), New Zealand, Australia and other jurisdictions.

place."[2] While the list continues to evolve, the Public Health Agency of Canada has identified the following list of social determinants of health:

- Income and Social Status
- Social Support Networks
- Education and Literacy
- Employment/Working Conditions
- Social Environments
- Physical Environments
- Personal Health Practices and Coping Skills
- Healthy Child Development
- Biology and Genetic Endowment
- Health Services
- Gender
- Culture[3]

Although many of the determinants that produce health disparities lie beyond the health care system itself, analysis of social determinants of health has the potential to clarify important pathways to health outcomes and may suggest powerful approaches to address identified health inequities. For a definition of each social determinant of health see Appendix A.

Purpose of HEIA

Addressing disparities in health service delivery and planning requires a solid understanding of key barriers to equitable access to high quality care and of the specific needs of health-disadvantaged populations; and this requires an array of effective and practical planning tools. HEIA is one part of this repertoire of equity-driven planning tools. It is not appropriate for all purposes. For example, HEIA is not as well suited as other equity tools for needs assessment, measuring and tracking action on equity, program and service evaluation, or strategic planning.

HEIA is often seen as a 'first-pass' screening tool that can assist decision makers in integrating equity considerations into new initiatives and more detailed planning. In this way, HEIA supports the achievement of the long term strategic priority of improved access and responding to the needs of diverse communities as identified as an important priority by the Ontario Ministry of Health and Long-Term Care.

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[2] *Closing the gap in a generation: Health equity through action on the social determinants of health*, 2008. The Commission identifies nine themes that it finds raise determinants of health: early child development, employment conditions, globalization, social exclusion, health systems, priority health conditions, women and equity, urbanization, measurement and evidence (www.who.int/social_determinants).

[3] For more information see PHAC website: http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#key_determinants. Determinants of health identified by other researchers and practitioners include income/wealth distribution and poverty, gender, race and ethnicity, citizenship and immigration status, language, ability, sexual orientation, age, racism and discrimination, social exclusion, and natural and built environments.

HEIA has five primary purposes for service providers:

- Help identify potential health impacts (positive or negative) of a plan, policy or program on vulnerable or marginalized groups within the general population

- Help develop recommendations as to what adjustments to the initiative might mitigate negative impacts as well as maximize positive impacts on the health of vulnerable and marginalized groups.

- Embed equity across an organization's existing and prospective decision-making models, so that it becomes a core value and one criterion to be weighed in all decisions.

- Support equity-based improvement in program/service design: "How does this program need to be adjusted to meet the needs of specific populations?" "Could this program benefit some, but not others?"

- Raise awareness about health equity as a catalyst for change throughout the organization, so planners and managers develop "stretch goals": How can we include more people in this program, especially those often missed? What barriers do we have to look for? Are we as effective as we could be, especially those with the greatest and most complex health needs?

HEIA can also offer a valuable framework for examining whether a provider's individual initiatives overall are exploiting available opportunities to improve equity or whether they may potentially result in widening the health disparities between vulnerable and marginalized populations and the general population.

While MOHLTC and LHINs may use HEIA to assess individual policies and planning initiatives, they may also apply HEIA at a macro level to assess their mix of current or planned initiatives with the goal of assessing that mix to determine whether it will potentially widen health disparities or improve health equity.

When to Conduct HEIA

HEIA should be conducted **as early as possible** in planning or proposal development to enable adjustments to the initiative before opportunities for change become more limited.

While early assessment is ideal, HEIA can still be introduced at later points within the planning or policy/program/proposal development cycle – during reviews or evaluations for program growth, realignment, or closure, for example. Resulting recommendations, however, may be constrained by factors such as earlier decisions, investments already

made, remaining resources, and time commitments. Nonetheless, these considerations should not limit or preclude an HEIA analysis.

Who Should Conduct HEIA

HEIA is typically conducted by the planning, policy, program or proposal development staff who will use the assessment in designing the initiative. The results of HEIA should then be considered by decision makers in the planning, policy, program or proposal development process.

Gathering the Evidence

HEIA provides a framework of analysis, while the user feeds in evidence appropriate for the effective consideration of potential equity impacts. The HEIA analysis is as robust as the quality of evidence fed into the tool. Mainstream research (i.e. quantitative and qualitative research studies) has tended not to equally reflect the realities and issues faced by marginalized or non-dominant population groups. As a result, users can sometimes experience difficulties in accessing mainstream evidence that relates specifically to the populations under consideration.

For best results, when undertaking an HEIA analysis consider using a 'realist' approach—integrating mainstream research evidence with broader streams, including:

- Grey literature (project/program reports, informal practice guidelines, recommended or promising practices etc.)
- Inter-jurisdictional evidence
- Online resources
- Consultation and community engagement findings
- Key informant interviews (e.g. with local experts or staff from relevant organizations)
- Program evaluation results
- Client surveys etc.

A broad consideration of evidence will facilitate a robust analysis and will ensure that the needs of populations that may experience exclusion from mainstream research are adequately considered in completing the HEIA. All evidence sources should be weighed based on their strength and quality

HEIA in Four Steps

If the initiative has the potential to impact the health of vulnerable or marginalized groups, HEIA is applicable. It is desirable that **all** initiatives be screened.

1. Scoping

Identify affected populations or groups and predict key impacts (positive or negative) on those groups. Consider a wide range of vulnerable or marginalized groups to avoid overlooking unexpected or unintended consequences of an initiative.

2. Impact Assessment

Use available data/evidence to prospectively assess the *unintended* impacts on vulnerable or marginalized groups in relation to the broader target population. It is both useful and important to consider a broader range of evidence including consultation findings and grey literature (including project or program reports, informal practice guidelines, recommended or promising practices). These sources of evidence should be weighed based on their strength and quality.

Where there is very limited data/evidence available, note the lack of evidence in the assessment or, where possible, implement other strategies to gather evidence. Strategies could include conducting surveys, focus groups, or consultation with experts or members of the affected groups where time permits.

3. Mitigation Strategy

Develop evidence-based recommendations to minimize or eliminate negative impacts and maximize positive impacts on vulnerable or marginalized groups. These recommendations comprise your mitigation strategy. Uptake of these recommendations in the roll out of the initiative will help to ensure that the initiative contributes to equity and does not perpetuate or widen existing health disparities. Where possible, recommendations should be informed by a diversity of members of the affected communities.

4. Monitoring and Evaluation

Determine how the rollout of the initiative will be monitored to determine its impacts on vulnerable or marginalized groups in comparison to other subpopulations or the broader target population. The resulting data will enhance the overall evidence base for equity-based interventions and can be fed back into the planning, policy or program development process.

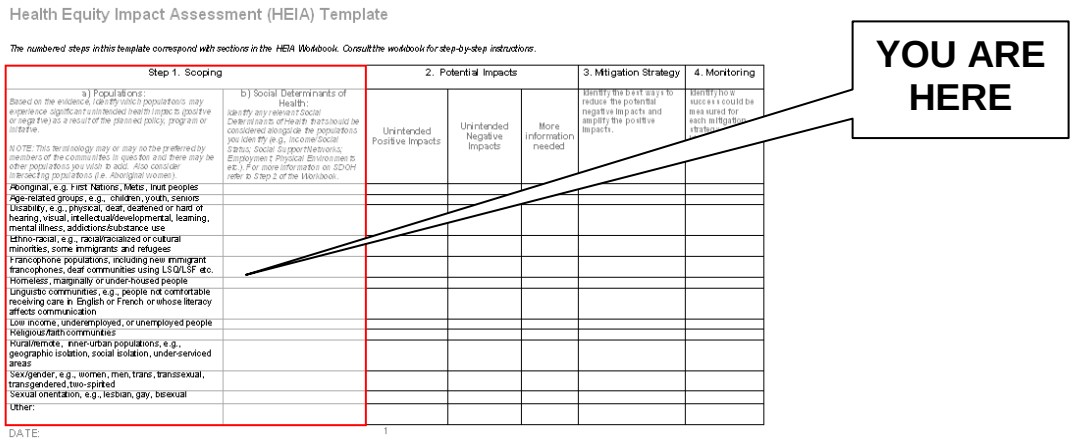
After the HEIA process has been completed, conduct a short process and impact evaluation of the completed HEIA process to determine whether the tool was practical and appropriate (process), as well as whether there was uptake of the recommendations for plan/policy/program adjustment made as part of the mitigation strategy (impact).

HEIA Template: Doing the Assessment

This section of the Workbook guides the user through each part of the HEIA Template, with prompts and examples. The examples are not meant to be comprehensive, but instead act as illustrations to guide analysis.

Note: Each numbered step in the Workbook corresponds to the appropriate step in the HEIA Tool. A graphic at the beginning of each section highlights where in the HEIA Tool you are located.

Step 1: Scoping Vulnerable or Marginalized Populations



While it is difficult to identify all groups that are vulnerable or marginalized with respect to a specific health initiative, disparities in access and quality of care have been repeatedly associated with some key sub-populations. Marginalized groups, however, may vary from one initiative to another. In completing the HEIA tool, the populations of concern will be identified by the assessor based on knowledge of the initiative, groups that would likely be impacted by the initiative and known or suspected barriers to care.

Questions

Determine if your initiative could have a positive or negative impact on the health of vulnerable or marginalized communities by asking questions such as:

- How does your program/service affect health equity for identified vulnerable or marginalized populations in your area?
- Will the program have a differential impact on people or communities that you serve? Will some clients have different access to care, or overall health outcomes, than others?
- Are there other vulnerable or marginalized communities which may experience unintended results of this program?

Ontario

Potential Vulnerable or Marginalized Populations (corresponds to column 1. a) in the HEIA Tool)

Note: The following populations are not exhaustive and the terminology used may or may not be preferred by members of the communities in question (as preferences can vary both within and across communities). If preferences are not known, it is helpful to seek guidance with respect to preferred terminology from local experts and representatives of the communities themselves. (Note that examples are provided under each population outlined below, in an effort to clarify populations listed)

When assessing your program under Step 1 of the HEIA Tool, vulnerable and marginalized subpopulations may include, but are not limited to, the following:

Aboriginal
First Nations, Inuit, Métis or other indigenous populations

Age-related groups
Children, seniors/elderly, youth

Disability
These can include, but are not limited to, a person with a physical or mental disability, infirmity, malformation or disfigurement such as blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, mental impairment (developmental or learning disability), a mental disorder, or a workplace injury or disability[4]

Ethno-racial Communities
Racial /racialized communities, cultural minorities, immigrants, refugees

Francophone
People who communicate in French as their primary official or preferred language, including new immigrant francophones, deaf communities using LSQ/LSF etc.

Homeless, marginally or under housed people
People without a permanent address or stable housing; transient people

Linguistic Communities
People uncomfortable receiving care in English/French or who prefer a first language other than English/French, or whose literacy level affects communication regardless of language spoken

[4] Ontario Human Rights Code, R.S.O. 1990

Low income, underemployed, or unemployed people
Economically vulnerable people

Religious/Faith Communities
Systems of religious beliefs or faith that may also include dietary or cultural practices

Rural/remote, inner-urban
People facing geographic or social isolation, or living in under-serviced areas

Sex/gender
Women, men, transsexual, transgendered, two-spirit

Sexual orientation
Lesbian, gay, bisexual

Other
Other relevant populations not captured elsewhere in the template, for example uninsured people (people without legal status in Canada and no government health insurance), people without a family doctor etc.

One of the most important considerations in determining health disparities is that these various lines of inequality and identity can intersect and often reinforce each other in individuals and communities: health disadvantages faced by homeless people with disabilities and limited literacy or English fluency will be even worse, and low-income older immigrant women may face specific multiple barriers. Disadvantage is almost always multi-dimensional.

Similarly, research on the SDoH indicates these different lines of inequality can themselves contribute to poorer prospects and positions within the labour market, which contributes to higher levels of poverty, poorer housing, and other SDoH.

Examples

When identifying vulnerable or marginalized populations, look for these kinds of health disparities as they relate to your initiative:

- If your initiative is designed to address a chronic condition such as arthritis, diabetes or depression, it is important to consider how it will impact on women. While Ontario women live longer than men, a majority are more likely to suffer from disability and chronic conditions. It is also important to consider low-income women as a vulnerable and marginalized population as this group have more chronic conditions, greater disability and a shorter life expectancy than women in higher income groups.[5]

[5] Bierman, A. et al. POWER Study, 2009.

- For a program or initiative that is designed to improve early year's health it would be important to take into the account the often poorer infant and child health of certain populations. For example, the death rate from injury for Aboriginal infants is four times the rate of that for infants in the broader Canadian population, while Aboriginal preschoolers experience five times the rate and teenagers experience three times the rate of death from injury experienced by the broader Canadian population.[6]

- If the goal of a program is to assist under-housed individuals obtain stable housing it would be important to keep in mind that homeless people often suffer from poorer health. In 2006, homeless people in Toronto were 20 times as likely to have epilepsy, five times as likely to have heart disease, four times as likely to have cancer, three times as likely to have arthritis or rheumatism, and twice as likely to have diabetes.[7] Acknowledging and developing methods to address these disparities could help make your program or initiative more effective.

- If you are developing a service that requires people to come into a hospital or clinic it will be important to identify populations that experience transportation barriers such as persons with physical disabilities, those with low incomes or those who are more geographically isolated. Additionally, if your initiative requires that individuals have access to a primary care physician or specialist, those who reside in rural areas may experience barriers. In 2004, 21.4% of the Canadian population lived in rural areas, where only 9.4% of physicians (15.7% of family physicians and 2.4% of specialists) practised.[8]

Identified Vulnerable Populations

Based on your research and analysis, have you identified vulnerable or marginalized groups who may be affected by your program/service? If so, identify them below.

Vulnerable or Marginalized Populations

1.
2.
3.
4.
5.

[6] Ibid.
[7] Khandor E & Mason K. *The Street Health Report 2007*. www.streethealth.ca
[8] Pong RW, Pitblado JR. *Geographic Distribution of Physicians in Canada: Beyond How Many and Where*. Ottawa: Canadian Institute for Health Information. 2006

6.
7.

It may be necessary to add rows to accommodate identified populations

Potential Impacts on Social Determinants of Health (corresponds to column 1. b) in the HEIA Tool)

Many vulnerable or marginalized populations are further impacted by SDoH. Examining the initiatives through a SDoH 'lens' may help identify additional potential adjustments that will reduce the disparate impact on these groups.

A program could have an effect beyond its formal objectives and targets on client social connectedness, skills building and labour market opportunities, or individual or family living conditions; all of which can have a major impact on health.

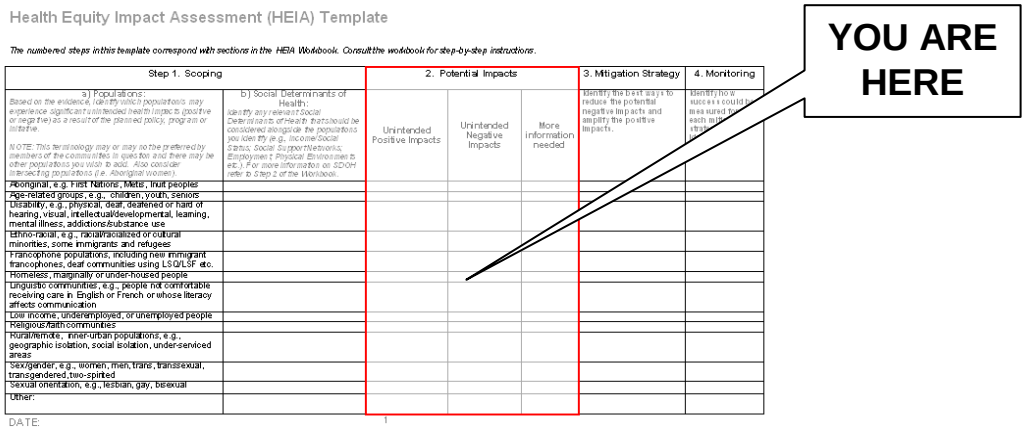
If positive or negative impacts on SDoH are identified they can be noted in column 1. b) adjacent to the corresponding population groups. Once recorded, impacts related to SDoH can be addressed through a mitigation (or enhancement strategy) as set out in Step 3 below. Examples of SDoH impacts might include:

- A health service for seniors was delivered in a community health setting, but is now redesigned to provide in-home service. This could result in a negative impact on social supports and connectedness by removing an opportunity for social interaction for isolated elderly individuals.
  a) Population: *seniors*
  b) SDoH: *Social Support Networks/Social Environments*

- A community kitchen program is designed to strengthen healthy eating behaviours for members of a specific ethno-cultural community at high risk for diabetes and its complications. The program has additional positive impacts relating to social connectedness for members of this community by bringing together members who might otherwise be isolated by both cultural and linguistic barriers. The positive impacts on social connectedness might be further enhanced in the program design by providing participants with additional social supports such as child care.
  a) Population: *specific ethno-cultural communities*
  b) SDoH: *Social Support Networks/Social Environments/Healthy Child Development*

- A network of health system navigators or “health ambassadors” is created to assist members of a community of recent immigrants who require assistance to overcome cultural and linguistic barriers to their health care. Navigators with medical or health system skills/expertise from their country of origin are hired from within the community to fill this role. Experience on this project is leveraged to overcome barriers to employment experienced by the health ambassadors themselves and to assist them to advance their careers in the health system in Ontario.
  a) Population: *recent immigrants/communities experiencing linguistic barriers*
  b) SDoH: *Social Support Networks/Social Environments/Employment and Literacy/ Income and Social Status*

Step 2: Impact Assessment



Once you have identified populations that could be affected by the initiative, the next step is to analyze the potential *unintended* impact on the health of these populations.

Questions

Determine whether your initiative will have a positive or negative impact on vulnerable or marginalized communities by asking questions such as.

- How will the program affect access to care for this population?
- Is it likely to have positive impacts or effects that enhance health equity?
- Is it likely to have negative effects that contribute to, maintain or strengthen health disparities?
- How will it affect the quality and responsiveness of care for this community?
- Will providing this program, or improving access to it, help to narrow the gap between the best and worst off in terms of health outcomes?
- If you don’t know, what more do you need to know and how will you find out?
- Will some people or communities benefit more from the program than others, and why?

Your appraisal should also consider:

- The nature and quality of the evidence you are using to assess impact
- The probability of the predicted impact(s)
- The severity and scale of the impact(s)
- Whether the impact(s) will be immediate or latent

Examples

- Imagine that a program is designed to increase access to pre-natal care for lower income women and is being rolled out in designated neighbourhoods, with a facility that will be open from 10:00 a.m. to 6:00 p.m. Many people with a low income work more than one job, or have a job that falls outside of traditional 9 to 5 hours. Taking this into consideration might mean that the hours of service for this facility would have to be altered to ensure access.

- You are planning to roll out a heart health awareness campaign. People with higher education and income levels typically use health promotion programs more, with the unintended consequence that these programs can serve to increase health disparities. Could this be the case here? Will the program be understandable and relevant for people from diverse cultural backgrounds? Not all groups communicate and access information in the same manner, and understanding how to best access your intended audience can contribute to your programs success.

Assessment of Potential *Unintended* Impact on Identified Populations (based on column 1. a) and b) in the HEIA Tool)

Thinking back to the vulnerable or marginalized groups and SDoH you identified in Step 1, what are the positive and negative impacts you have identified for each of the groups? It may be necessary to rely on research and analysis to determine these impacts.

Use the table below to help record the *unintended* positive and negative impacts you have identified for each group. If your initiative is neutral in its impact with respect to a specific group, indicate this with N/A under each of the impact columns.

Potential Impacts on Identified Populations

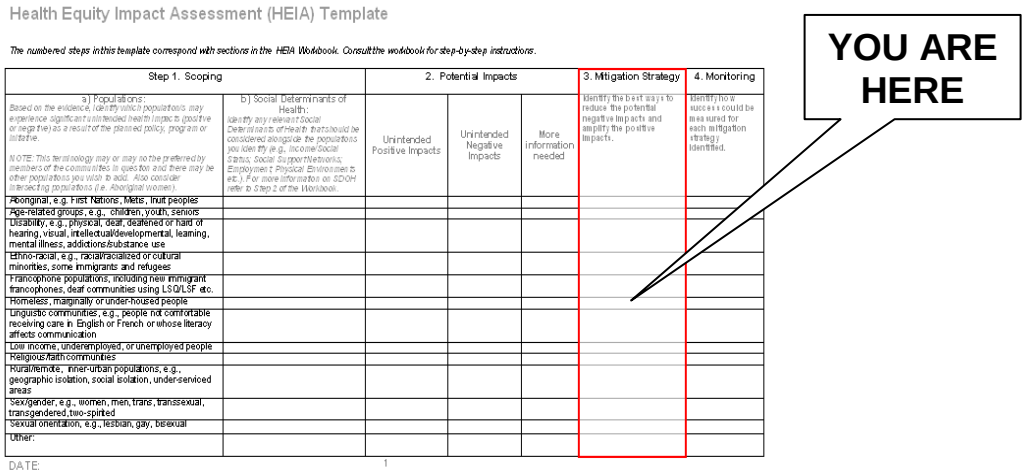
Positive Impacts	Negative Impacts
Population 1:	1:
Population 2:	2:
Population 3:	3:

Population 4:	4:
Population 5:	5:
Population 6:	6:
Population 7:	7:

It may be necessary to add rows to accommodate more impacts

Note: In some instances, you will identify the fact that you require further data/evidence in order to more accurately identify the impacts of your initiative on a specific population. In this instance, you may identify this information in the "More Information Needed" column of the HEIA Tool. If information cannot be located within program timelines, the missing information should be noted in the template as a possible missing component of the analysis.

Step 3: Mitigation Strategy



Once you have identified the impacts of your initiative, the next step is to plan how to minimize the negative effects of your initiative that create or contribute to existing health disparities, and to maximize positive impacts you have identified.

Questions

Analyze how the impact of your initiative will be mitigated by asking questions such as:

- How can you reduce or remove barriers and other inequitable effects?
- How you can you maximize the positive effects or benefits that enhance health equity?
- What specific changes do you need to make to the initiative so it meets the needs of each vulnerable or marginalized communities you have identified? How does it need to be customized or targeted?
- Could you engage the population in designing and planning these changes or consult with key stakeholders?
- How will the program address systemic barriers to equitable access to care created by the health care and other systems?
- Will you be making recommendations to decision makers?

Examples

- If a cancer screening program is being designed to reach women in low-income neighbourhoods, its strategies might include extending opening hours to accommodate a range of work schedules, ensure it is located in a building easily accessible by public transit, and provide free child care services for those women who require it. If a particular low-income neighbourhood has one or more significant ethnoracial populations, strategies should also address potential barriers to these groups, such as barriers related to linguistic accessibility, cultural competence or system navigation.

- Community Health Centres and others have employed strategies that include training and supporting community-based peer workers in outreach and system navigation services to overcome language and cultural barriers: e.g., lay people from particular ethno-cultural communities provide health promotion to particular communities, in the language and culture they understand.

- Language can be a significant barrier to care and a real quality problem if it leads to poor communication between patients and providers (and possible misdiagnoses or inappropriate prescriptions or treatment). Common directions have included enhanced interpretation services, engaging directly with affected language and other communities, and training in culturally competent care.

- Some populations can have particularly complex needs and/or be particularly difficult to reach. Psychiatric services have been delivered to homeless people in shelters and other non-medical sites, rather than assuming homeless people will come into hospitals or clinics to receive psychiatric care. These services can be combined with multi-disciplinary care and support to address the underlying reasons individuals are homeless (i.e., SDoH).

- Some Community Health Centres directly provide or partner with other agencies to offer employment, literacy and other services that address the underlying roots of ill health in poverty and broader social determinants of health in supporting their clients.

Strategy/Strategies

For each of the *unintended* negative and positive impacts identified in Step 2 above, outline the recommended adjustments to the initiative you will make in order to:

- Reduce unintended negative impacts on the populations identified, in Step 1 and/or
- Maximize unintended positive impacts on the populations identified in Step 1

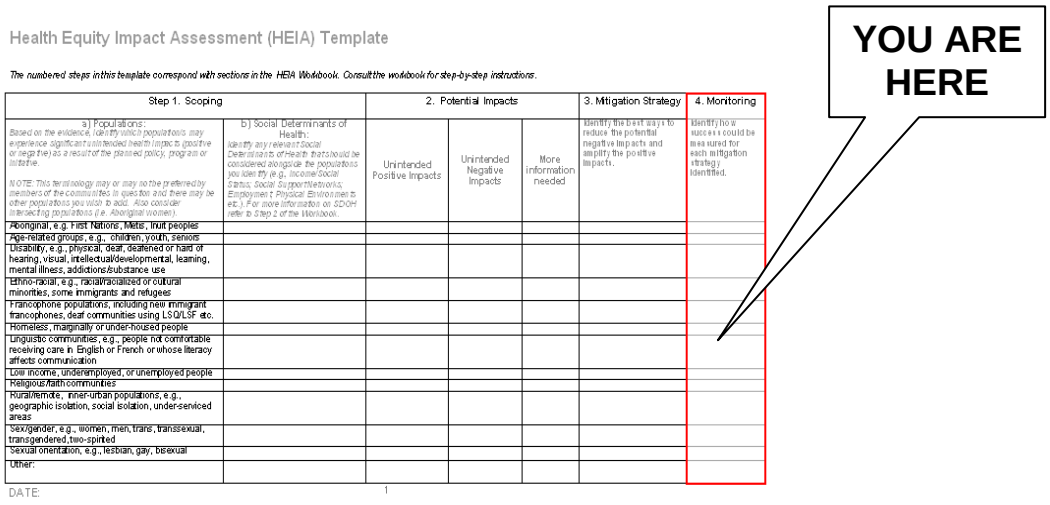
Please use this table to help identify mitigation strategies to either reduce negative impacts or maximize positive impacts for impacts you have identified for particular population groups in Step 2.

Mitigation Strategies

Impacts (from Step 2)	**Mitigation Strategy**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.

It may be necessary to add rows to accommodate more strategies

Step 4: Monitoring



Health Equity Impact Assessment (HEIA) Template

The numbered steps in this template correspond with sections in the HEIA Workbook. Consult the workbook for step-by-step instructions.

Step 1. Scoping		2. Potential Impacts			3. Mitigation Strategy	4. Monitoring
a] Populations: *Based on the evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.* *NOTE: This terminology may or may not be preferred by members of the communities in question and there may be other populations you wish to add. Also consider intersecting populations (i.e. Aboriginal women).*	b] Social Determinants of Health: *Identify any relevant Social Determinants of Health that should be considered alongside the populations you identify (e.g., Income/Social Status; Social Support Networks; Employment; Physical Environments; etc.). For more information on SDOH refer to Step 2 of the Workbook.*	Unintended Positive Impacts	Unintended Negative Impacts	More information needed	Identify the best ways to reduce the potential negative impacts and amplify the positive impacts.	Identify how success could be measured for each mitigation strategy identified.
Aboriginal, e.g. First Nations, Metis, Inuit peoples						
Age-related groups, e.g., children, youth, seniors						
Disability, e.g., physical, deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use						
Ethno-racial, e.g., racial/racialized or cultural minorities, some immigrants and refugees						
Francophone populations, including new immigrant francophones, deaf communities using LSQ/LSF etc.						
Homeless, marginally or under-housed people						
Linguistic communities, e.g., people not comfortable receiving care in English or French or whose literacy affects communication						
Low income, underemployed, or unemployed people						
Religious/faith communities						
Rural/remote, inner-urban populations, e.g., geographic isolation, social isolation, under-serviced areas						
Sex/gender, e.g., women, men, trans, transsexual, transgendered, two-spirited						
Sexual orientation, e.g., lesbian, gay, bisexual						
Other:						

DATE: 1

YOU ARE HERE

The final step of the HEIA is to determine, if possible, how roll-out of the initiative will be monitored to determine its impacts on vulnerable or marginalized groups identified in the analysis. Once finalized, the monitoring strategy should be integrated within the overall evaluation/performance measurement plan for the initiative. The resulting data will enhance the evidence base and feed back into the planning, policy or program development process.

Questions

Analyze how the impact of your initiative will be monitored by asking questions such as:

- *How will you know if your program has enhanced equity?*
- *How will you know when the program is successful? What equity indicators and objectives will you measure, and how?*

Examples

There are many ways you can monitor the impacts on equity as your initiative is implemented. For example:

- Client satisfaction surveys –surveys could be provided to members of identified vulnerable or marginalized populations for example to monitor quality of care issues; or the broader population could be surveyed with results stratified by gender, ethno-cultural background or socio-economic status.

- Monitoring the organization's broader community engagement activities for information and feedback from particular marginalized populations.

- Program evaluation that disaggregates and tracks measures of program success by vulnerable or marginalized groups (e.g., tracking hospital re-admission or cancer screening rates).

- Process evaluation to ensure that planners, program and policy developers and decision makers are integrating equity considerations into their processes.

- Consultation with key providers and other stakeholders on how they are seeing the equity impact of the initiative; focus groups with affected populations.

Monitoring Strategy

Please describe your monitoring strategy below.

Monitoring Strategy:

Appendix A

Social Determinants of Health Defined

Source: The Public Health Agency of Canada website

http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#income

What Makes Canadians Healthy or Unhealthy?

This deceptively simple story speaks to the complex set of factors or conditions that determine the level of health of every Canadian.

"Why is Jason in the hospital?
Because he has a bad infection in his leg.
But why does he have an infection?
Because he has a cut on his leg and it got infected.
But why does he have a cut on his leg?
Because he was playing in the junk yard next to his apartment building and there was some sharp, jagged steel there that he fell on.
But why was he playing in a junk yard?
Because his neighborhood is kind of run down. A lot of kids play there and there is no one to supervise them.
But why does he live in that neighborhood?
Because his parents can't afford a nicer place to live.
But why can't his parents afford a nicer place to live?
Because his Dad is unemployed and his Mom is sick.
But why is his Dad unemployed?
Because he doesn't have much education and he can't find a job.
But why ...?"

- from Toward a Healthy Future: Second Report on the Health of Canadians

There is a growing body of evidence about what makes people healthy. The Lalonde Report[9] set the stage in 1974, by establishing a framework for the key factors that seemed to determine health status: lifestyle, environment, human biology and health services. Since then, much has been learned that supports, and at the same time, refines and expands this basic framework. In particular, there is mounting evidence that the contribution of medicine and health care is quite limited, and that spending more on health care will not result in significant further improvements in population health. On the

[9] Lalonde, M. A new perspective on the health of Canadians. A working document. Ottawa: Government of Canada, 1974. http://www.phac-aspc.gc.ca/ph-sp/pube-pubf/perintrod-eng.php

other hand, there are strong and growing indications that other factors such as living and working conditions are crucially important for a healthy population.

The evidence indicates that the key factors which influence population health are: income and social status; social support networks; education; employment/ working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture.

Each of these factors is important in its own right. At the same time, the factors are interrelated. For example, a low weight at birth links with problems not just during childhood, but also in adulthood. Research shows a strong relationship between income level of the mother and the baby's birth weight. The effect occurs not just for the most economically disadvantaged group. Mothers at each step up the income scale have babies with higher birth weights, on average, than those on the step below. This tells us the problems are not just a result of poor maternal nutrition and poor health practices associated with poverty, although the most serious problems occur in the lowest income group. It seems that factors such as coping skills and a sense of control and mastery over life circumstances also come into play.

The following Underlying Premises and Evidence Table provides an overview of what we know about the ways the determinants influence health.
The source documents are:

Toward a Healthy Future: Second Report on the Health of Canadians. A complementary report -- *Statistical Report on the Health of Canadians (1999).* The Federal, Provincial and Territorial Advisory Committee on Population Health for the Meeting of Ministers of Health, Charlottetown, P.E.I[10]

and

Strategies for Population Health: Investing in the Health of Canadians[11].

Underlying Premises and Evidence Table

[10] http://www.phac-aspc.gc.ca/ph-sp/report-rapport/toward/index-eng.php
[11] http://www.phac-aspc.gc.ca/ph-sp/resources-ressources/index-eng.php

KEY DETERMINANT -- 1. Income and Social Status	
UNDERLYING PREMISES	**EVIDENCE**
Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth. Why are higher income and social status associated with better health? If it were just a matter of the poorest and lowest status groups having poor health, the explanation could be things like poor living conditions. But the effect occurs all across the socio-economic spectrum. Considerable research indicates that the degree of control people have over life circumstances, especially stressful situations, and their discretion to act are the key influences. Higher income and status generally results in more control and discretion. And the biological pathways for how this could happen are becoming better understood. A number of recent studies show that limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems.	There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health. **Evidence from the Second Report on the Health of Canadians** ▪ Only 47% of Canadians in the lowest income bracket rate their health as very good or excellent, compared with 73% of Canadians in the highest income group. ▪ Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes, regardless of age, sex, race and place of residence. ▪ At each rung up the income ladder, Canadians have less sickness, longer life expectancies and improved health. ▪ Studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned by society members. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole. **Evidence from Investing in the Health of Canadians:** ▪ Social status is also linked to health. A major British study of civil service employees found that, for most major categories of disease (cancer, coronary

	heart disease, stroke, etc.), health increased with job rank. This was true even when risk factors such as smoking, which are known to vary with social class, were taken into account. All the people in the study worked in desk jobs, and all had a good standard of living and job security, so this was not an effect that could be explained by physical risk, poverty or material deprivation. Health increased at each step up the job hierarchy. For example, those one step down from the top (doctors, lawyers, etc.) had heart disease rates four times higher than those at the top (those at levels comparable to deputy ministers). So we must conclude that something related to higher income, social position and hierarchy provides a buffer or defence against disease, or that something about lower income and status undermines defences. ▪ See also evidence from the report *Social Disparities and Involvement in Physical Activity*[12] ▪ See also evidence from the report Improving the Health of Canadians[13] ▪ See also **The Social Determinants of Health:** *income inequality*[14] and *food security*[15]*:* ▪ *Are poor people less likely to be healthy than rich people?*[16] This question was

[12] Gauvin, L and the Interdisciplinary Research Group on Health. Social Disparities and Involvement in Physical Activities, Montreal (2003). http://www.gris.umontreal.ca/rapportpdf/R03-02.pdf
[13] https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367
[14] Scott, K and Lessard, R. Income Inequality as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/02_income_e.pdf
[15] McIntyre, L and Tarasuk, V. Food Security as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/08_food-eng.php
[16] http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr1-eng.php

	prepared for the Canadian Health Network by the Canadian Council on Social Development.
KEY DETERMINANT -- 2. Social Support Networks	
UNDERLYING PREMISES	**EVIDENCE**
Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems. In the 199697 National Population Health Survey (NPHS), more than four out of five Canadians reported that they had someone to confide in, someone they could count on in a crisis, someone they could count on for advice and someone who makes them feel loved and cared for. Similarly, in the 199495 National Longitudinal Survey of Children and Youth, children aged 10 and 11 reported a strong tendency toward positive social behaviour and caring for others.	**Evidence from Investing in the Health of Canadians:** Some experts in the field have concluded that the health effect of social relationships may be as important as established risk factors such as smoking, physical activity, obesity and high blood pressure. ■ An extensive study in California found that, for men and women, the more social contacts people have, the lower their premature death rates. ■ Another U.S. study found that low availability of emotional support and low social participation were associated with all-cause mortality. ■ The risk of angina pectoris decreased with increasing levels of emotional support in a study of male Israeli civil servants. ■ See also **The Social Determinants of Health:** *social inclusion and exclusion*[17] *and social economy*[18] ■ *How do relationships with others affect people's health?*[19] This question was

[17] Galabuzi, G-E and Labonte, R. Social Inclusion as a Determinant of Health. Summary of paper and presentations prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/03_inclusion-eng.php
[18] Vaillancourt, Y and Armstrong, P. Social Policy as a Determinant of Health: The Contribution of the Social Economy. Summary of paper and presentations prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/03_inclusion-eng.php
[19] http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr2-eng.php

	prepared for the Canadian Health Network by the Canadian Council on Social Development.
KEY DETERMINANT -- 3. Education and Literacy	
UNDERLYING PREMISES	**EVIDENCE**
Health status improves with level of education. Education is closely tied to socioeconomic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy.	**Evidence from the Second Report on the Health of Canadians:** ▪ Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy ▪ People with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier foods. ▪ In the 1996-97 National Population Health Survey (NPHS), only 19% of respondents with less than a high school education rated their health as "excellent" compared with 30% of university graduates. **Evidence from Investing in the Health of Canadians:** ▪ The 1990 Canada Health Promotion Survey found the number of lost workdays decreases with increasing education. People with elementary schooling lose seven work days per year due to illness, injury or disability, while

	those with university education lose fewer than four days per year. ■ See also evidence from the report: *How Does Literacy Affect the Health of Canadians?*[20] ■ See also **The Social Determinants of Health:** education[21] ■ How does education affect health?[22] This question was prepared by the Canadian Council on Social Development.
KEY DETERMINANT -- 4. Employment / Working Conditions	
UNDERLYING PREMISES	**EVIDENCE**
Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.	**Evidence from the Second Report on the Health of Canadians:** ■ Employment has a significant effect on a person's physical, mental and social health. Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. When a person loses these benefits, the results can be devastating to both the health of the individual and his or her family. Unemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job. ■ Conditions at work (both physical and psychosocial) can have a profound effect on people's health and emotional well-being. ■ Participation in the wage economy, however, is only part of the picture. Many Canadians (especially women)

[20] http://www.phac-aspc.gc.ca/ph-sp/literacy-alphabetisme/index-eng.php
[21] http://www.phac-aspc.gc.ca/ph-sp/oi-ar/10_education-eng.php
[22] http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr3-eng.php

	spend almost as many hours engaged in unpaid work, such as doing housework and caring for children or older relatives. When these two workloads are combined on an ongoing basis and little or no support is offered, an individual's level of stress and job satisfaction is bound to suffer. Between 1991 and 1995, the proportion of Canadian workers who were "very satisfied" with their work declined, and was more pronounced among female workers, dropping from 58% to 49%. Reported levels of work stress followed the same pattern. In the 199697 NPHS, more women reported high work stress levels than men in every age category. Women aged 20 to 24 were almost three times as likely to report high work stress than the average Canadian worker. **Evidence from Investing in the Health of Canadians:** ▪ A major review done for the World Health Organization found that high levels of unemployment and economic instability in a society cause significant mental health problems and adverse effects on the physical health of unemployed individuals, their families and their communities. ▪ See also **The Social Determinants of Health:** employment and job security[23] and working conditions[24]

[23] Tremblay, D-G. Employment Security as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/04_employment_e.pdf

[24] Andrew Jackson, A. and Polanyi, M. Working Conditions as A determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/05_working_e.pdf

KEY DETERMINANT -- 5. Social Environments	
UNDERLYING PREMISES	**EVIDENCE**
The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province or country. It is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others. The array of values and norms of a society influence in varying ways the health and well being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. A healthy lifestyle[25] can be thought of as a broad description of people's behaviour in three inter-related dimensions: individuals; individuals within their social environments (eg. family, peers, community, workplace); the relation between individuals and their social enivronment. Interventions to improve health through lifestyle choices can use	**Evidence from the Second Report on the Health of Canadians[26]** ▪ In the U.S., high levels of trust and group membership were found to be associated with reduced mortality rates. ▪ Family violence has a devastating effect on the health of women and children in both the short and long term. In 1996, family members were accused in 24% of all assaults against children; among very young children, the proportion was much higher. ▪ Women who are assaulted often suffer severe physical and psychological health problems; some are even killed. In 1997, 80% of victims of spousal homicide were women, and another 19 women were killed by a boyfriend or ex-boyfriend. ▪ Since peaking in 1991, the national crime rate declined 19% by 1997. However, this national rate is still more than double what it was three decades ago.

[25]Lyons, R. and Langille L. Health Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health. Prepared for Health Canada (2002). http://www.phac-aspc.gc.ca/ph-sp/docs/healthy-sain/pdf/lifestyle.pdf

[26] *Toward a Healthy Future: Second Report on the Health of Canadians.* A complementary report -- *Statistical Report on the Health of Canadians* (1999). The Federal, Provincial and Territorial Advisory Committee on Population Health for the Meeting of Ministers of Health, Charlottetown, P.E.I. http://www.phac-aspc.gc.ca/ph-sp/report-rapport/toward/pdf/toward_a_healthy_english.PDF

comprehensive approaches that address health as a social or community (ie. shared) issue. Social or community responses can add resources to an individual's repertoireof strategies to cope with changes and foster health. In 1996-97: - Thirty-one percent of adult Canadians reported volunteering with not-for-profit organizations in 1996-97, a 40% increase in the number of volunteers since 1987. - One in two Canadians reported being involved in a community organization. - Eighty-eight percent of Canadians made donations, either financial or in-kind, to charitable and not-for-profit organizations.	
KEY DETERMINANT -- 6. Physical Environments	
UNDERLYING PREMISES	**EVIDENCE**
The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments. In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.	**Evidence from the Second Report on the Health of Canadians** ■ The prevalence of childhood asthma, a respiratory disease that is highly sensitive to airborne contaminants, has increased sharply over the last two decades, especially among the age group 0 to 5. It was estimated that some 13% of boys and 11% of girls aged 0 to 19 (more than 890,000 children and young people) suffered from asthma in 199697. ■ Children and outdoor workers may be

	especially vulnerable to the health effects of a reduced ozone layer. Excessive exposure to UV-B radiation can cause sunburn, skin cancer, depression of the immune system and an increased risk of developing cataracts **Evidence from Investing in the Health of Canadians:** ▪ Air pollution, including exposure to second hand tobacco smoke, has a significant association with health. A study in southern Ontario found a consistent link between hospital admissions for respiratory illness in the summer months and levels of sulphates and ozone in the air. However, it now seems that the risk from small particles such as dust and carbon particles that are by-products of burning fuel may be even greater than the risks from pollutants such as ozone. As well, research indicates that lung cancer risks from second hand tobacco smoke are greater than the risks from the hazardous air pollutants from all regulated industrial emissions combined. ▪ See also **The Social Determinants of Health:** housing[27] ▪ What affects health more: germs and viruses, or the environment?[28] This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

[27] Bryant, T., Chisholm, S. and Crowe, C. Housing as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/09_housing_e.pdf

[28] http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr4-eng.php

KEY DETERMINANT -- 7. Personal Health Practices and Coping Skills	
UNDERLYING PREMISES	**EVIDENCE**
Personal Health Practices and Coping Skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health. Definitions of lifestyle[29] include not only individual choices, but also the influence of social, economic, and environmental factors on the decisions people make about their health. There is a growing recognition that personal life "choices" are greatly influenced by the socioeconomic environments in which people live, learn, work and play. These influences impact lifestyle choice through at least five areas: personal life skills, stress, culture, social relationships and belonging, and a sense of control. Interventions that support the creation of supportive environments will enhance the capacity of individuals to make healthy lifestyle choices in a world where many choices are possible. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and	**Evidence from the Second Report on the Health of Canadians** ■ In Canada, smoking is estimated to be responsible for at least one-quarter of all deaths for adults between the ages of 35 and 84. Rates of smoking have increased substantially among adolescents and youth, particularly among young women, over the past five years and smoking rates among Aboriginal people are double the overall rate for Canada as a whole. ■ Multiple risk-taking behaviours, including such hazardous combinations as alcohol, drug use and driving, and alcohol, drug use and unsafe sex, remain particularly high among young people, especially young men. ■ Diet in general and the consumption of fat in particular are linked to some of the major causes of death, including cancer and coronary heart disease. The proportion of overweight men and women in Canada increased steadily between 1985 and 199697 < from 22% to 34% among men and from 14% to 23% among women. **Evidence from Investing in the Health of Canadians:** ■ Coping skills, which seem to be acquired

[29] Lyons and Langille, Ibid.

other adverse health events. However, there is a growing recognition that personal life "choices" are greatly influenced by the socioeconomic environments in which people live, learn, work and play. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.	primarily in the first few years of life, are also important in supporting healthy lifestyles. These are the skills people use to interact effectively with the world around them, to deal with the events, challenges and stress they encounter in their day to day lives. Effective coping skills enable people to be self-reliant, solve problems and make informed choices that enhance health. These skills help people face life's challenges in positive ways, without recourse to risky behaviours such as alcohol or drug abuse. Research tells us that people with a strong sense of their own effectiveness and ability to cope with circumstances in their lives are likely to be most successful in adopting and sustaining healthy behaviours and lifestyles. ■ See also evidence from the report *Social Disparities and Involvement in Physical Activity*[30] ■ See also evidence from the report *Improving the Health of Canadians*[31]
KEY DETERMINANT -- 8. Healthy Child Development	
UNDERLYING PREMISES	**EVIDENCE**
New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right. At the same time, we have been learning more about how all of the other determinants of health affect the physical,	**Evidence from the Second Report on the Health of Canadians** Experiences from conception to age six have the most important influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health

[30] Gauvin, Ibid.
[31] https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367

social, mental, emotional and spiritual development of children and youth. For example, a young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic makeup and access to dental and medical care.	into adulthood. Tobacco and alcohol use during pregnancy can lead to poor birth outcomes. In the 199697 National Population Health Survey, about 36% of new mothers who were former or current smokers smoked during their last pregnancy (about 146,000 women). The vast majority of women reported that they did not drink alcohol during their pregnancy. A loving, secure attachment between parents/caregivers and babies in the first 18 months of life helps children to develop trust, self-esteem, emotional control and the ability to have positive relationships with others in later life. Infants and children who are neglected or abused are at higher risk for injuries, a number of behavioural, social and cognitive problems later in life, and death. **Evidence from Investing in the Health of Canadians:** A low weight at birth links with problems not just during childhood, but also in adulthood. Research shows a strong relationship between income level of the mother and the baby's birth weight. The effect occurs not just for the most economically disadvantaged group. Mothers at each step up the income scale have babies with higher birth weights, on average, than those on the step below. This tells us the problems are not just a result of poor maternal nutrition and poor health practices associated with poverty, although the

	most serious problems occur in the lowest income group. It seems that factors such as coping skills and sense of control and mastery over life circumstances also come into play. See also evidence from the report Improving the Health of Canadians[32] See also **The Social Determinants of Health:** early childhood education and care[33]
KEY DETERMINANT -- 9. Biology and Genetic Endowment	
UNDERLYING PREMISES	**EVIDENCE**
The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems.	**Evidence from the Second Report on the Health of Canadians** Studies in neurobiology have confirmed that when optimal conditions for a child's development are provided in the investment phase (between conception and age 5), the brain develops in a way that has positive outcomes for a lifetime. Aging is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning may be particularly important for maintaining health and cognitive capacity in old age. And studies on education level and dementia suggest that exposure to education and lifelong learning may create reserve capacity in the brain that compensates for cognitive losses that occur with biological aging.
KEY DETERMINANT -- 10. Health Services	

[32] Ibid
[33] Friendly, M. and Browne, G. Early Childhood Education and Care as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/07_ecec_e.pdf

UNDERLYING PREMISES	EVIDENCE
Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health. The health services continuum of care includes treatment and secondary prevention	**Evidence from the Second Report on the Health of Canadians** Disease and injury prevention activities in areas such as immunization and the use of mammography are showing positive results. These activities must continue if progress is to be maintained. There has been a substantial decline in the average length of stay in hospital. Shifting care into the community and the home raises concerns about the increased financial, physical and emotional burdens placed on families, especially women. The demand for home care has increased in several jurisdictions, and there is a concern about equitable access to these services. Access to universally insured care remains largely unrelated to income; however, many low- and moderate-income Canadians have limited or no access to health services such as eye care, dentistry, mental health counselling and prescription drugs.
KEY DETERMINANT -- 11. Gender	
UNDERLYING PREMISES	**EVIDENCE**
Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. "Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-	**Evidence from the Second Report on the Health of Canadians** Men are more likely to die prematurely than women, largely as a result of heart disease, fatal unintentional injuries, cancer and suicide. Rates of potential years of life

based social status or roles.	lost before age 70 are almost twice as high for men than women and approximately three times as high among men aged 20 to 34. While women live longer than men, they are more likely to suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence. While overall cancer death rates for men have declined, they have remained persistently stubborn among women, mainly due to increases in lung cancer mortality. Teenage girls are now more likely than adolescent boys to smoke. If increased rates of smoking among young women are not reversed, lung cancer rates among women will continue to climb. See also articles on Rural, remote and northern women - where you live matters to your health and How being Black and female affects your health
KEY DETERMINANT -- 12. Culture	
UNDERLYING PREMISES	**EVIDENCE**
Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.	Evidence from the **Second Report on the Health of Canadians** Despite major improvements since 1979, infant mortality rates among First Nations people in 1994 were still twice as high as among the Canadian population as a whole and the prevalence of major chronic diseases, including diabetes, heart problems,

	cancer hypertension and arthritis/rheumatism, is significantly higher in Aboriginal communities and appears to be increasing. In a comparison of ethnic groups, the highest rate of suicide occurred among the Inuit, at 70 per 100,000, compared with 29 per 100,000 for the Dene and 15 per 100,000 for all other ethnic groups, comprised primarily of non-Aboriginal persons. The 1996-97 National Longitudinal Survey of Children and Youth found that many immigrant and refugee children were doing better emotionally and academically than their Canadian born peers, even though far more of the former lived in low-income households. The study suggests that "poverty among the Canadian-born population may have a different meaning than it has for newly arrived immigrants. The immigrant context of hope for a brighter future lessens poverty's blows; the hopelessness of majority-culture poverty accentuates its potency." See also evidence from the report Improving the Health of Canadians[34]

[34] https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367

Appendix B

Other Health Equity Resources

Project for an Ontario Women's Health Evidence-Based Report, *the POWER Study* http://www.powerstudy.ca/

Echo : Improving Women's Health in Ontario : http://www.echo-ontario.ca./echo/en.html

Public Health Agency of Canada: www.phac-aspc.gc.ca

Ontario Health Quality Council: www.ohqc.ca

Toronto-based Health Equity Council: www.healthequitycouncil.ca

National Institute of Public Health in Quebec: http://www.ncchpp.ca/en/

World Health Organization: www.who.int/social_determinants

HIA gateway (UK): http://www.apho.org.uk/default.aspx?QN=P_HEIA

HIA connect (NSW Australia): http://www.HEIAconnect.edu.au/

WHO HIA site: http://www.who.int/hia/en/